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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Morocco

The Executive Director recommends that the Executive Board approve the country programme of Morocco for the period 1992 to 1996 in the amount of $13,200,000 from general resources, subject to availability of funds, and $11,800,000 in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, this document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1991, will be contained in the "Summary of 1992 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.2 and Add.1).

THE SITUATION OF CHILDREN AND WOMEN

1. The population of Morocco is estimated at nearly 26 million and, at a natural annual growth rate of 2.6 per cent, it is expected to double roughly every 25 years. The population is characterized by its youth - 40 per cent of the total population is under 15, 51 per cent is under 20. Fertility has declined noticeably since the beginning of the 1960s; the female fertility rate dropped from 7.2 in 1962, to 5.7 in 1982 and to 4.5 in 1987, representing a decline of nearly 38 per cent in 25 years. The decline is more pronounced in urban areas than in rural areas. For economic reasons, almost 50 per cent of the population is concentrated in two regions, the Centre and the North-west. Rapid urbanization will raise the urban population from 46.5 per cent in 1991 to 51.2 per cent of the total population by the year 2000 (Ministry of Planning).

2. The Moroccan economy remains subject to many limitations. In 1990, the outstanding external debt represented almost 90 per cent of the gross domestic product (GDP), placing a serious strain on the country's financing capacity and limiting its development financing resources. According to the estimates of the Ministry of Planning, the urban unemployment rate in 1990 was 15.8 per cent: 14.2 per cent for men and 20.4 per cent for women. Unemployment is found even among those who have diplomas. A national survey conducted in 1991 by the National Council for Youth and the Future counted 100,374 such people (high-school graduates, university graduates and technicians) seeking jobs. Moreover, Morocco was particularly affected by the situation between Iraq and Kuwait which had a negative impact on port traffic, tourism and related sectors such as transport, handicrafts and the hotel industry. The loss of Iraq and Kuwait as suppliers of oil at preferential prices further burdens the balance of payments.

3. Over the past 20 years, Morocco has experienced a significant decline in mortality among children under five. Since 1962, the infant and child mortality rate has dropped by 50 per cent and the infant mortality rate (IMR) by 38 per cent, with neonatal mortality falling by 29 per cent. According to recent surveys the infant and child mortality rates are 73 per 1,000 live births and 102 per 1,000 respectively. Expansion and acceleration of the National Immunization Programme has helped to improve the situation and reduce the incidence of target diseases. Despite these significant and encouraging results, however, infant and child mortality rates remain extremely high, with major disparities from one region and area to another.

4. Diarrhoeal disease is the leading cause of death in children under the age of five (39 per cent), followed by infectious diseases (22 per cent) and acute respiratory infections (ARI) (14 per cent). Malnutrition is a factor in at least 22 per cent of cases. The incidence of delayed growth and low weight in this age group remains high, 20 per cent and 28.2 per cent respectively (Ministry of Public Health (MSP)/UNICEF, 1990). Furthermore, iodine deficiency disorders have been noted, in the mountainous areas in particular (for example, the incidence of goitre reaches an average of 65 per cent in Azilal province).

5. The maternal mortality rate is high - between 300 and 585 per 100,000 live births according to sources (MSP/World Bank). A current concern is to determine the exact situation with regard to maternal mortality, its causes and existing disparities. Currently, the leading causes are believed to stem from medical-obstetrical problems, pregnancy when the women is too young or too old, lack of pre-natal care (74 per cent of cases) and conditions of delivery (only 6 per cent of deliveries are attended by a doctor and 20 per cent by a nurse or midwife).

6. Since independence, education has been a major priority in Morocco's development policy. The share of the State budget allocated to education has grown from 17 per cent in 1961 to more than 23 per cent in 1988. Progress has undeniably been achieved: between 1961 and 1989, primary school enrolment more than doubled, increasing by 2.5, and the rate of enrolment for 7-year-olds grew from 13 per cent in 1960 to almost 67 per cent in 1990. However, these results still fall short of the goals set in the various development plans. The school dropout rate remains high and varies tremendously from one province to another (ranging from 24 per cent to 98.7 per cent). The rate of school enrolment among girls remains far below the national average, especially in rural areas, no more than 36.7 per cent in 1990 (Ministry of Education). Illiteracy remains widespread among young people and is even greater in rural areas. Among women, illiteracy is especially high; according to the 1982 census, 95 per cent of rural women and 57 per cent of urban women are illiterate.

7. With regard to water supply, 76 per cent of the urban population has access to running water in the household, while 24 per cent gets its water from standpipes. In rural areas, the percentages are 2 per cent and 20 per cent, respectively. The rest of the population gets its water - which is often of doubtful quality - from a variety of sources (springs, wells, wadis, cisterns, irrigation ditches). Sanitation facilities are extremely rare. It is estimated that close to three fourths of rural villages and 69 per cent of the urban population have no sanitation system. In 83 per cent of rural villages, women and children fetch the drinking water, spending from 2 to 4 hours each day to get about 80 litres of water.

8. The issue of children and women in urban fringe areas is becoming of increasing concern. Rapid urbanization has led to a proliferation of shantytowns where basic services (health, education, water and sanitation) are in scanty supply. According to surveys conducted in 1990 (Moroccan Child Protection League/UNICEF) there are several categories of children in especially difficult circumstances (children without families, street children, working children, etc.).

9. In Morocco women as a social group have lagged behind others where development is concerned. It is true that, since independence, women have experienced many changes, both quantitative and qualitative but although they make up 51.1 per cent of the population, do not have equal access to education, particularly in rural areas. So far as their status is concerned, women do not yet enjoy sufficient protection under the law.

PROGRAMME COOPERATION, 1987-1991

10. The programme of cooperation for the period 1987-1991 sought to reduce infant and child mortality through actions such as immunization and the control of diarrhoeal disease (CDD) and efforts to improve basic services. The components of the programme were as follows: health and nutrition; water and sanitation; education; and women in development.

Health and nutrition

11. During that five-year period, cooperation with the Government developed at an unprecedented rate through the activities carried out in the area of immunization. The national programme of immunization had spectacular results and the objective of universal immunization was achieved as a result of the tremendous expansion of the programme after 1987.

12. Benefiting from the personal support of the Head of State and the royal family, successive immunization campaigns were organized, backed by a high level of social mobilization. The permanent programme was strengthened; the number of immunization centres doubled; 2,000 itinerant health workers participated in immunization activities; and the planning and management of the activities were decentralized. This success transcended frontiers since the heads of State of other Maghreb countries supported the Moroccan initiative and decided to designate 14 October as Maghreb immunization day. The assistance provided by UNICEF helped to ensure a steady supply of vaccines, to increase cold chain capacity to develop human resources, to strengthen logistical and monitoring resources, and also information, education and communication (IEC).

13. According to the 1991 cluster survey (MPH/UNICEF) immunization coverage (each antigen) among children under the age of one is over 90 per cent and among women of child-bearing age, in respect of the anti-tetanus vaccine (ATV), it is 64 per cent. The Government is now trying to work out an alternative strategy which would achieve the same results at a lower cost, particularly as regards the immunization of women against tetanus. Despite the improvement in the performance of the permanent programme, 37 per cent of women are immunized only during campaigns.

14. With regard to CDD, UNICEF concentrated its assistance on training health personnel, health education, monitoring, operational research and supplying packets of oral rehydration salts (ORS). The Ministry of Public Health organized national and provincial campaigns to promote oral rehydration therapy but this did not suffice to achieve all the desired results. The project slowed down somewhat due to implementation problems and poor performance of the programme generally, as well as to technical factors related, in part, to difficulties in producing ORS packets locally. UNICEF provided over 5 million packets, which helped, inter alia, to alleviate the problems resulting from the shut-down of the production factory. Assistance was sought from other partners, including the private sector, and this offers better prospects for the project, which remains a public health priority.

15. To promote maternal and child health, the activities undertaken concentrated on growth monitoring and nutrition. Special emphasis was placed on the promotion of breast-feeding, weaning, personal hygiene and food hygiene. Messages from Facts for Life concerning maternal and child nutrition were widely disseminated. UNICEF support made it possible to provide baby scales, supplies and equipment for health centres and medical kits for midwives; a training manual was prepared for traditional birth attendants. However, inaccessibility of health services for a large part of the population has continued to hamper the project. In view of the situation, UNICEF helped conduct an experiment for drawing up a plan to extend health coverage for some poorly served districts. The lessons drawn from this experiment are regarded as a significant contribution to improved quality of care and better planning of health resources.

Water and sanitation

16. The efforts undertaken were designed to support and supplement the drinking water supply activities that had been initiated and implemented by local communities in rural areas. The objective was also to develop community participation in water activities. The UNICEF contribution consisted of training and technical assistance, supply of materials and equipment, and logistical resources. In this context, over 200 manual pumps were installed; the pump heads, for the most part, were manufactured locally. Water points were equipped with pumping systems (solar, wind, motor and electric pumps). These installations corresponded to 84 per cent and 96 per cent, respectively, of the initial objectives.

17. The sanitation and hygiene activities did not follow on after the water supply activities because they were carried out outside project areas, and this limited their impact. The programme had to be refocused so as to progress from purely technical aspects to activities to improve the quality of the services delivered. Thus, collective modified latrine units were introduced in rural schools and biogas compacters were built for demonstration purposes. Moreover, 60 engineers and technicians were trained - they now constitute the provincial maintenance teams - and health information and education activities were organized around water points. The programme was adversely affected, however, by the low capacity of provincial services in respect of planning, project identification and programming.

Education

18. The activities envisaged for the programme were as follows:
(a) restructuring and adapation of traditional Koranic pre-school teaching to meet the educational and development needs of the child; (b) incorporation of health and nutritional education in primary education; (c) launching of pilot projects for the functional literacy of women; (d) contribution to the establishment of a unit to train specialized teachers to care for handicapped children. Thus, 350 teaching advisers were trained to supervise schools and provide group orientation for the fuqaha' (teachers in Koranic schools), who were also trained in early learning and stimulating activities for young

children. A teaching manual was prepared as a reference work for the fuqaha' and also a specific guide on health. However, an in-depth evaluation of the activities has been found necessary because of the obstacles encountered: the large number of participants, the content of teaching, the scattered locations of Koranic schools, the limited participation by girls, and the low levels of pay of the fuqaha'. In respect of primary education, the health and nutrition component was introduced in official primary education programmes. UNICEF helped the Government develop a set of teaching modules for teacher and student at the first six levels. In order to promote the use of these modules in all the provinces of the Kingdom, information and training sessions were organized for school principals.

Advancement of women

19. The objectives of this programme were: (a) to increase food supplies at the family level by providing technical and financial support for rural women; (b) to disseminate information on health, hygiene and nutrition to women in rural and urban fringe areas; (c) to promote schooling for girls in rural areas. To this end, several training sessions were held for agricultural extension workers on varied subjects such as: livestock rearing, bee-keeping, market gardening, communication techniques, farm management and biogas. Training days in the fields of health, family planning, literacy and manual work were organized for 350 female instructors in women's centres. Studies were carried out on the situation of women to identify the provinces where their situation is most critical, for example Chefchaouen (UNICEF, 1990). Training and awareness campaigns were carried out regarding the importance of schooling for girls. However, the activities undertaken are still very limited. The problems of "women in development" therefore remain.

Advocacy

20. Sustained advocacy efforts were undertaken as support for the programme, particularly in the field of immunization, using modern communications facilities (radio and television) and traditional methods such as folklore troupes, asuaq (souks) (covered markets) and mauasim (seasonal festivals). Special emphasis was placed on the Convention on the Rights of the Child and on activities relating to the World Summit for Children and the Plan of Action which resulted from it. Advocacy for girls with decision makers and influential bodies was intensified. In May 1991, a Maghreb symposium entitled "Girls too", organized under the auspices of the Moroccan Association for UNICEF (AMS) in cooperation with UNICEF, brought together researchers from the countries concerned to consider the specific problems impeding the development of girls, to make decision makers aware of the importance of the issue and to formulate recommendations that can be implemented throughout the Maghreb.

Lessons drawn from previous experience

21. Past cooperation concentrated on universal child immunization and much has been learned from that experience. In particular, it has shown that the country is able to mobilize for child health, and also to set objectives and

to achieve them. The political will that was demonstrated, the networks that were established with non-governmental organizations (NGOs) and associations, and good media coverage have created a favourable environment for the acceleration of future activities to benefit children. Similarly, the experience acquired in the expanded programme on immunization (EPI) will be put to use in systematically carrying out "packages" of activities to benefit children and women, particularly in respect of diarrhoeal disease, promotion of maternal health and other sectoral programmes.

22. Disparities persist between the sexes and between regions as regards coverage of basic services; it is therefore necessary to protect social sectors from the impact of structural adjustment measures. New problems are appearing in urban fringe areas and they require particular attention. Activities will certainly be necessary at the national level, but it would be wise to concentrate efforts on priority geographical areas so as to maximize impact, reduce disparities and carry out integrated activities to ensure greater family participation. In this respect, water supply activities would serve as a point of entry and a catalyst for integration in rural areas. This will involve implementing the recommendations of the evaluation of the Ministry of the Interior/UNICEF (1990) and bringing systems more into line with the need of users, particularly women and children.

RECOMMENDED PROGRAMME COOPERATION, 1992-1996

General resources: $13,200,000
Supplementary funds: $11,800,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Basic health	6 030	6 750	12 780
Education	545	500	1 045
Integrated basic services in rural areas	4 975	4 050	9 025
Children in difficult circumstances in urban fringe areas	400	500	900
Planning, social mobilization and advocacy	1 250	-	1 250
Total	13 200	11 800	25 000

a/ The breakdown for estimated yearly expenditures is given in table 3 below.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Preparation of the programme

23. The principles to be observed in implementing this country programme were established in the light of: priority problems of children and women revealed by the situation analysis; lessons learnt from previous cooperation (1987-1991); priorities of the Government's economic and social policy relating to children and women; the Convention on the Rights of the Child; the World Declaration and the Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s; UNICEF's medium-term plan for 1991-1993; and cooperation with multilateral and bilateral organizations and with NGOs.

Purposes and objectives

24. The Government is preparing a new five-year economic and social development plan for the period 1993-1997, the broad lines of which coincide with the purposes and objectives of the World Summit. This cooperation programme is part of those efforts and supports the following objectives: (a) placing and maintaining children on the political agenda and among the top political priorities of national development; (b) reducing the IMR, estimated at 73 per 1,000 live births, by one quarter by 1996; (c) reducing the child mortality rate, estimated at 102 per 1,000 live births, by one quarter by 1996; and (d) reducing the maternal mortality rate (MMR) by 10 per cent by 1996.

Programme strategy and components

25. The country programme will be implemented by means of a two-tier strategy to be applied at the national level and at the level of specific (rural and urban fringe) geographical areas. At all these levels, girls are to be the key theme running through the programme and equality of girls and boys is to be one of the main indicators of performance. At the national level, this will mean supporting the implementation of policies and the development of structures in the fields of health and education. IEC, social mobilization and advocacy have been treated as an integral part of all sectoral programmes. These programmes will also benefit from the improvement of planning capabilities and the strengthening of statistical structures relating to the situation of children, girls and women.

26. At a decentralized level, action is planned in very limited geographical areas with the aim of, on the one hand, reducing disparities between the provinces while optimizing assistance to target communities in rural areas and, on the other, helping to solve the problems encountered by particular categories of children in urban fringe areas. Integrated activities at community level will be developed and undertaken with the participation of community members, adopting a dynamic approach that will involve the beneficiaries in identifying their problems, seeking the most effective solutions and introducing mechanisms for the gradual recovery of costs. The lessons learned from such an approach may be turned to account in other areas. With that end in view, the 1992-1996 country programme is built around the five programmes described below.

Basic health

27. The basic health programme is organized around five projects based on an integrated primary health care (PHC) approach.

28. The objectives of the EPI project are as follows: (a) to achieve and maintain 95 per cent immunization coverage during the 1990s for children under one year of age; (b) to achieve 90 per cent immunization coverage for women of child-bearing age with at least two doses of anti-tetanus vaccine and to maintain that rate during the 1990s; (c) to eliminate neonatal tetanus as a cause of death by 1995; (d) to reduce the gross annual incidence of measles among children under one year of age from over 2,000 cases to less than 500 cases by the end of 1996, and to eliminate the illness as a cause of death. In addition, the EPI project supports the Government's aim of eradicating poliomyelitis by 1996. The Government and UNICEF, with the backing of Rotary International, have undertaken to ensure that the project is sustained and to consolidate the advances achieved. In this connection, an approach known as the "immunizational independence initiative" has been developed so that the Government can gradually take over responsibility for ensuring a steady supply of vaccines.

29. UNICEF's contribution will consist of technical assistance, strengthening of the cold chain and provision of injection and sterilization equipment. Epidemiological surveillance will be increased in order to identify the localize low-coverage and high-risk areas. To that end, emphasis will be placed on training personnel at the intermediary and peripheral levels and on improving and computerizing services at the central and provincial levels. Continued immunization work will make it easier to control ARI and will speed up action with respect to the other components of PHC.

30. The CDD project is designed to reduce mortality and morbidity related to diarrhoeal diseases by one quarter among the under-fives by 1996 and to promote prevention in this same area. Much of the project will consist of IEC, with special emphasis on home treatment, training and retraining. UNICEF will provide support for training courses in the form of practical programmes for health professionals and instruction in supervisory techniques for provincial officials. All fixed vaccination centres will gradually be provided with the requisite facilities (materials and equipment, staff) for proper handling cases of diarrhoeal disease. UNICEF will continue to supply packets of oral rehydration salts (ORS), while encouraging the Ministry of Public Health to develop local production capacities under optimum conditions. The IEC campaigns will form an integral part of water supply, hygiene and sanitation activities (integrated basic services in rural areas programme). Special attention will be given to the prevention of cholera. A mass breast-feeding campaign will be organized with the assistance of the United States Agency for International Development and national NGOs.

31. The aims of the ARI control project are: (a) to reduce deaths due to acute respiratory infections by 10 per cent among children under five years of age; (b) to reduce the severity of ARI among children and the attendant

serious complications; (c) to check the misuse of antibiotics and other drugs in the treatment of ARI among children. Action will focus on the development of human resources and each year a planning workshop, a training seminar for doctors and paramedical staff and an information meeting for private-sector doctors and pharmacists will be organized at the provincial level. Special attention will be given to the promotion of breast-feeding and to immunization against whooping cough and measles as support activities. UNICEF will supply the medicines needed to consolidate the initial phase of the project, and will strengthen planning and promote the introduction of appropriate practical procedures for handling cases in health establishments in the pilot regions.

32. The promotion of safe motherhood aims at achieving a 10 per cent reduction in MMR and a one third reduction in neonatal mortality by 1996. This will mean increasing the number and improving the quality of regular prenatal and postnatal check-ups, improving delivery conditions both at home and in medically supervised facilities and increasing the percentage of women receiving proper assistance during childbirth from 26 to 50 per cent. Support will focus on intensifying IEC activities in local communities and enhancing the capacity of maternity clinics.

33. UNICEF will assist in training birth attendants, supplying materials and equipment and following a study, making available appropriate means of evacuation (transport). The IEC activities will include education in the prevention of acquired immune deficiency syndrome (AIDS), in child growth and nutrition and in combating iron deficiency anaemia. The "baby-friendly hospitals" approach will be tested and introduced in a number of national hospitals and subsequently in maternity hospitals. The complexity of the problem calls for a gradual approach. Assistance will initially be provided to two provinces and then extended to two more before the end of the cycle. It will supplement the assistance being provided by other bodies such as the United Nations Population Fund (UNFPA), USAID and the World Health Organization (WHO).

34. The iodine deficiency project will involve the establishment by 1996 of facilities for the elimination of iodine deficiency disorders in Azilal, Taza, Chechaouèn and Khenifa, the four provinces where the incidence of such disorders is high. Studies of the prevalence of goitre will be undertaken in those areas. UNICEF will support initiatives aimed at prevention through the provision of iodine supplements, which will evolve into an overall salt and/or water iodization strategy based on the socio-economic and geographical characteristics of the individual provinces.

Education

35. This programme forms part of the Government's programme to achieve universal basic education by the year 2000. With that in view, it is supporting the following national efforts: (a) to improve the quality of basic education; (b) to promote education for girls, particularly in rural areas; (c) to advocate that girls should remain at school at least throughout the period of basic education; (d) to promote early childhood development

within the family context, with the emphasis on parental responsibility and roles; (e) to strengthen local literacy skills; and (f) to encourage literacy among girls and young women. The main aim of the activities is to ensure that a health/nutrition component is included as a general principle in the basic education curriculum. Efforts will also be made to foster the role of the child as an "agent of development", who will transmit the knowledge acquired at school to parents, children and the community.

36. In this framework, UNICEF will continue to assist in devising educational documents, training educators at regional level in the use of the new curriculum and in organizing information days for heads of educational establishments. With regard to IEC, the programme will be based on the ideas set forth in Facts for Life and will seek to use the third channel to promote, at national level, early childhood development within the family context and to encourage education for girls as well as boys. The programme will receive assistance from other partners including the World Bank, the United Nations Development Programme (UNDP), the World Food Programme (WFP), the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the United Nations Population Fund (UNFPA).

37. With regard to literacy, the aim is to include courses on literacy methodology and on adult education in the teacher-training curriculum and also to provide retraining for female literacy instructors in women's centres. Support will be given for training, the preparation of a guide for educators and a manual for women instructors, and for provision of teaching materials (audio-visual materials, documentation, etc.).

Integrated basic services in rural areas

38. One of the concerns of the country programme is to reduce the disparities between provinces with regard to child survival. Five provinces have been selected for the current programme, namely Chechaouèn and Tata (both already chosen for the iodine deficiency project), El Haouz, Ifrane and Taza. The selection was based on a series of indicators. In fact, the vast majority of the people of these five provinces live in rural areas, where scattered settlements, fragile infrastructure and isolation make life particularly difficult for women and children, to whom is left, almost exclusively, the chore of fetching water and collecting wood. These areas also have low school enrolment rates and very high IMR.

39. The programme was prepared in close collaboration with the central and provincial authorities and joint field trips were undertaken, making it possible to determine the field of action in each province. The target provinces have a population of almost 1 million, 35 per cent of whom will benefit directly from the programme.

40. The integrated basic services programme is designed to speed up social development in these areas by stimulating a vigorous demand for services capable of improving the situation of children and women, while at the same time mobilizing local resources, including those of the community, in order to

meet this demand. The programme is based on the development of local skills in the planning and management of community activities. The goals are to: (a) reduce infant and child mortality and morbidity rates by 30 per cent by 1996; (b) provide adequate access to drinking water, sanitation and hygiene for 300,000 inhabitants; (c) reduce the incidence of water-borne diseases; (d) alleviate the drudgery of fetching water for women and children; (e) increase preschool and school enrolment rates by more than 25 per cent from their current respective levels of 26 per cent and 66 per cent; (f) promote literacy among girls and women; (g) provide the guidance necessary to stimulate activities capable of generating substantial levels of income; and (h) broaden the knowledge of female agricultural extension workers and encourage women to play a leadership role. IEC is an integral part of this process. The programme will be implemented gradually. Initially, actions will be focused in two provinces and then extended in stages to the other provinces.

Children in difficult circumstances in urban fringe areas

41. The current programme seeks to facilitate access to basic services for disadvantaged children and their families in urban fringe areas. As this is Morocco's first experience with UNICEF assistance, the programme's objectives are confined to devising solutions to avert the problems faced by children in especially difficult circumstances in these areas and drawing on experience and research to identify suitable ways of assisting the most disadvantaged sectors of the population.

42. The programme will begin with the organization of a workshop bringing together operators familiar with the sector in order to determine the nature, scope and the location of problems and to identify dynamic groups among the community who can help carry out the activities. The programme will be implemented initially in the urban areas around Salé and later in the town of Fez. It will attempt to bring together the various aspects of child survival, particularly basic health, hygiene and sanitation, the strengthening of women's survival capacity (income), and improved formal and informal education. The experience gained will be used extensively for the purposes of advocacy and application in other areas.

Planning, social mobilization and advocacy

43. This programme provides opportunities for accelerating the different components of the present country programme. Its aims are to: (a) include and maintain children among the main priorities for national development policies and promote measures to assist them on a national scale; (b) extend and strengthen affiliation networks; and (c) help strengthen the capacity of statistical and planning structures. UNICEF will provide support for the preparation and dissemination of IEC equipment, training and awareness activities and for strengthening the use of computers for statistics and planning.

44. The ratification and implementation of the Convention on the Rights of the Child and the adoption and execution of the national action programme advocated by the World Summit for Children are priority objectives. With that in view, the Ministry of Social Affairs has been given responsibility for coordinating the national programme with the help of a technical committee which includes representatives from the other Ministries concerned. Within this specific framework, a monitoring unit and a data bank will be set up at the Ministry of Planning, in order to keep track of progress made in achieving the objective set for the 1990s.

Monitoring and evaluation

45. In the light of the experience already gained in the development of indicators, the Government and UNICEF have undertaken to consolidate existing systems (mechanisms for the gathering, analysis and dissemination of information) at national and provincial levels so as to monitor regularly the progress of the programme and measure its impact. Mid-term evaluations of the health programme (EPI/CDD/ARI), and of the iodine deficiency and integrated services programmes, are scheduled for 1993. These will provide the basis for a mid-term review to be held during the second quarter of 1994 to assess the implementation of the programme and make any necessary adjustments for the remainder of the cycle. Basic studies will be undertaken at national level for certain target diseases and at regional level to obtain basic data in the provinces covered by the integrated activities. Impact assessments are scheduled for 1996 for infant and child mortality and morbidity rates, including those related to the target diseases, as well as for the programme components relating to water and sanitation, education, and children in urban fringe areas. The programmes and projects will be monitored through field trips and annual reviews. The latter will make it possible to identify what studies and project evaluations are necessary and to prepare annual action plans. In addition, the priority accorded to global objectives, and more specifically to girls as a major beneficiary of the country programme, will also be reflected in the monitoring of indicators at central and provincial level and the establishment and development of a database on gender differences.

Programme management plan 1992-1996

46. A management plan has been drawn up for the implementation of the country programme. It analyses the structure of the programme and the way in which it has been designed, taking into account the order of priority of objectives and the link between objectives and the human and financial resources available for their attainment. The UNICEF office in Rabat has been restructured to make it more responsive to the requirements of the programme.

Collaboration with partners

47. Collaboration with multilateral and bilateral organizations, as well as with NGOs, will be pursued and extended with a view to achieving closer coordination of actions and optimum use of resources so as to achieve maximum

impact. In the field of health, the main partners will be WHO, UNFPA and USAID. In the field of education, UNESCO, WFP, UNFPA, UNDP, the World Bank and UNICEF will work together. Other partners will include the NGOs, notably the Moroccan Association for UNICEF (AMS) and the Moroccan Child Protection League.

Initiatives by the Maghreb countries

48. As they did with the Maghreb immunization days, which have now become a regular event, the five Maghreb countries will join forces in other areas, namely the status of girls; preschool education; promotion of safe motherhood; and children without families. Indicators will be devised to specifically monitor these areas of common concern, in order to promote and gauge the success of Maghreb initiatives. Morocco will continue to play a key role in promoting this regional approach, which offers greater scope for the effective application of measures to ensure the survival, development and protection of Maghreb children.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Morocco (1990 and earlier years) UNICEF country classification

Under-five mortality rate	112	(1990)	High U5MR
Infant mortality rate	75	(1990)	High IMR
GNP per capita	$ 950	(1990)	Lower-middle GNP
Total population	25.1 Million	(1990)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1990
Births	(thousands)	717	731	793	858
Infant deaths (under 1)	(thousands)	93	76	71	64
Under-five deaths	(thousands)	137	112	105	96
Under-five mortality rate (per 1,000 live births)		191	153	132	112
Infant mortality rate (under 1) (per 1,000 live births)		130	104	90	75

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980/1987)	Moderate & severe	..	16a/
	Severe	5	4a/
Babies with low birth weight (%, 1979/1987)		..	..
% of primary school children reaching final grade (1980/1988)		..	67

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1987)		83/ 75/ 62	87 /77/59
Prevalence of wasting (%, 1980/1987)		..	6
Prevalence of stunting (%, 1980/1987)		..	34b/
Daily per capita calorie supply (% of requirements, 1979-1981/1988)		114	117
Food production per capita index (Index 1979-1981=100, 1980/1990)		107	124
Household expenditure (% of total income, 1987)	All food/cereals		40*/12*

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1989)			14
Access to health services	Total	52	70
(% of population, 1980/1985)	Urban/rural	93 / 24	100/ 50
Access to safe water	Total	30*	61
(% of population, 1980/1988)	Urban/rural	63*/ 2*	100/ 25
Access to adequate sanitation	Total	..	..
(% of population, 1985)	Urban/rural	.. /..	../ 16
Births attended by trained personnel (%, 1980/1990)		29	26*
Maternal mortality rate (per 100,000 live births, 1974)		300	..

Immunization		1981	1985	1990
One-year-olds (%) immunized against:	Tuberculosis	..	78	96
	DPT	43	46	81
	Polio	45	46	81
	Measles	..	42	79
Pregnant women (%) immunized against	Tetanus	..	..	64

/...

TABLE 1 (continued)

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	78/ 58	67/ 55
(%, 1980/1988)	Male	96/ 71	80/ 65
	Female	59/ 45	53/ 44
Secondary enrolment ratio (gross/net)	Total	25/ 20	36/ ..
(%, 1980/1988)	Male	32/ 24	43/ ..
	Female	19/ 15	30/ ..
Adult literacy rate, 15 years & older	Total	22	50
(%, 1970/1990)	Male/female	34/ 10	61/ 38
Radio/television sets			
(per 1,000 population, 1980/1988)		155/39	207/ 55c/

DEMOGRAPHIC INDICATORS		1970	1980	1985	1990	2000**
Total population	(Million)	15.3	19.4	22.0	25.1	31.6
Population aged 0-15 years	(Million)	..	8.8	9.7	10.7	12.3
Population aged 0-4 years	(Thousands)	..	3199.4	3413.7	3775.0	4036.9
Urban population (% of total)		35	41	44	48	55
Life expectancy at birth	Total	52	57	59	62	67
(years)	Male	50	55	58	60	65
	Female	53	59	61	64	69
Total fertility rate		7.0	5.7	5.1	4.5	3.3
Crude birth rate (per 1,000 population)		47	38	36	34	27
Crude death rate (per 1,000 population)		17	12	11	9	7

		About 1980	Most recent
Contraceptive prevalence rate		20	36
(%, 1980/1987)			
Population annual growth rate	Total	2.5	2.6
(%, 1965-1980/1980-1990)	Urban	4.2	4.1

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate		2.7	1.6
(%, 1965-1980/1980-1990)			
Inflation rate (%, 1965-1980/1980-1989)		6	7
Population in absolute poverty	Urban/rural	28/ 45	../ ..
(%, 1979)			
Household income share	Top 20%/bottom 40%	../ ..	../ ..
(%)			
Government expenditure	Health/education	3/ 17	3/ 17
(% of total expenditure, 1980/1987)	Defence	18	15
Household expenditure	Health/education		3/ 6
(% of total income, 1980-1985)			
Official development assistance:	US$ millions	894	443
(1980/1989)	As % of GNP	5	2
Debt service			
(% of goods & services exports, 1980/1989)		27	26

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

a/ Aged 0-36 months.

b/ Aged 24-36 months.

c/ Licences only.

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TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1987-1991

(In thousands of United States dollars)

COUNTRY: MOROCCO
LATEST BOARD APPROVAL: 1987
GENERAL RESOURCES: $9,020,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	4916	1520	131	70	110		1936	239	7093	1829	8922
Water supply and sanitation	1535	94	89		234		213	3	2071	97	2168
Nutrition	176		24		24		108		332		332
Education	101		184		186		241		712		712
Community organization and development	108		10				44		162		162
Women-centred programme	37		127		82		122		368		368
Children in especially difficult circumstances	57		9	5			21	32	87	37	124
Advocacy	5	5			107		27	1	139	6	145
Planning and project support	153				308		159	16	620	16	636
Freight	215	13					3		218	13	231
GRAND TOTAL	7303	1632	574	75	1051		2874	291	11802 a/	1998	13800

GR = General resources.
FSF = Funded supplementary funding.
a/ Including allocations to fund unfunded supplementary funding and allocations from global funds.

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TABLE 3. PLANNED EXPENDITURE, 1992-1996

(In thousands of United States dollars)

Country: MOROCCO Period covered: 1992-1996	Funding status	1992	1993	1994	1995	1996	Total
Health	GR	1185	1165	1215	1215	1250	6030
	FSF	98					98
	NSF	1350	1350	1450	1400	1200	6750
Education	GR	125	100	110	120	90	545
	NSF	100	120	90	80	110	500
Children in especially difficult circumstances	GR	80	80	100	90	50	400
	NSF	70	90	110	100	130	500
Planning and social mobilization	GR	270	290	220	230	240	1250
Integrated area-based programme	GR	980	1005	995	985	1010	4975
	FSF	140					140
	NSF	1260	755	770	330	935	4050
TOTAL	GR	2640	2640	2640	2640	2640	13200
	FSF	238					238
	NSF	2780	2315	2420	1910	2375	11800
GRAND TOTAL		5658	4955	5060	4550	5015	25238

GR = General resources.
NSF = New supplementary funding.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: MOROCCO	Number of posts	Amount (Thousands of United States dollars)
FINANCED FROM 1992-1993 APPROVED BUDGET:		
International Professional established posts	1	252
Local national Professional and General Service established posts	6	295
Operating costs		356
Total	7	903
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	1	226
Supplementary funds		
Local national Professional and General Service project posts		
General resources	9	602
Supplementary funds	1	39
Total	11	867

a/ For information source, see the 1992 revised post authorization table, dated 23 July 1991.